DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2003 — 11

2. STATE: Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
June 7, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.10 and 482

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ 1,088
b. FFY 2004 $ 3,350

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-E, page 1
Attachment 4.19-A, Part I, Version 23
Attachment 4.19-B, pages 1 and 45

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-E, page 1
Attachment 4.19-A, Part I, Version 22
Attachment 4.19-B, page 1

10. SUBJECT OF AMENDMENT:
Adult Liver Transplant Services - Change in Reimbursement Method

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Will be sent when received

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bob Sharpe

13. TYPED NAME:
Bob Sharpe

14. TITLE:
Deputy Secretary for Medicaid

15. DATE SUBMITTED:
June 12, 2003

16. RETURN TO:
Mr. Bob Sharpe
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Building 3, MS# 8
Tallahassee, FL 32308

ATTN: Kay Newman

17. DATE RECEIVED: JUN 16 2003

18. DATE APPROVED: NOV 17 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUN - 7 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
[signature]

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director, CMSO

23. REMARKS:

State/Territory: FLORIDA

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

For children under age 21, Florida covers organ transplants that are medically necessary and appropriate. For recipients age 21 and older, Florida covers kidney, liver, cornea, heart, lung, and bone marrow transplants that are medically necessary. An exception is that Medicaid covered emergency services for undocumented aliens, illegal aliens and legal non-immigrants do not include care and services related to organ transplant procedures. An adult heart transplant procedure and adult liver transplant procedure requires prior authorization. Other transplant procedures performed at approved transplant hospitals in Florida do not require prior authorization from the Medicaid office. All out-of-state transplants and evaluations require prior authorization.

Prior authorization is requested using the Florida Medicaid Authorization Request Form to which must be attached documentation by the transplant team, indicating that the recipient is a suitable transplant candidate. The medical consultants within the Medicaid office base their determination regarding prior authorization on the recommendation made by the transplant team, and documentation submitted. Each transplant team maintains its own criteria for determining whether an eligible Medicaid recipient may be considered for suitability as a transplant candidate.

Organ transplants for Florida Medicaid recipients are restricted to organ transplant hospitals that meet Medicare participation requirements of 42 CFR 440.10 and 482 and are approved by the Secretary of the Agency for Health Care Administration (AHCA) upon the recommendation of the Organ Transplant Advisory Council (FS 381.0602) as a designated Medicaid transplant facility. The Organ Transplant Advisory Council and AHCA approve the standards by which the transplant hospitals are evaluated and selected. These standards, which specify the qualifications of the facility and medical staff for each approved transplant hospital, are provided in Attachment 3.1-E, Supplement I.

Post transplant services are payable as long as they are medically necessary, covered under Medicaid and included in the State Plan. Coverage for post-transplant services begins once the transplant recipient has been discharged from the inpatient hospital. Post transplant services include any medically necessary physician, outpatient, inpatient, laboratory, pharmacy and radiology services.
All other program limitations apply.

Attachment 4.19-B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF FLORIDA

PAYMENT FOR SERVICES

Page

Amendment [illegible] 3-11
Effective [illegible] 03
Supersedes [illegible] 57
Approval NOV 17 2003

METHODS USED IN ESTABLISHING PAYMENT RATES

00/00/00 Reimbursement for adult (age 21 and over) heart and liver transplant evaluation and transplant surgery services will be paid the actual billed charges up to a global maximum rate established by the Agency. These payments will be made to physicians and facilities that have met specified guidelines and are established as designated transplant centers as appointed by the Secretary of the Agency. The global maximum reimbursement for transplant surgery services is an all-inclusive payment and encompasses 365 days of transplant related care. Only one provider may bill for the evaluation phase, and only one provider may bill for the transplant phase.

Global maximum rates for liver transplants are as follows:

Evaluation phase:	Physicians	$6,000
	Facility	9,000
	Total	$15,000

Transplant Surgery phase:

	Physicians	$27,000
	Facility	95,600
	Total	122,600

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FLORIDA TITLE XIX INPATIENT HOSPITAL

REIMBURSEMENT PLAN

VERSION XXIII

EFFECTIVE DATE: _____

I. Cost Finding and Cost Reporting

A. Each hospital participating in the Florida Medicaid Hospital Program shall submit a cost report postmarked no later than 5 calendar months after the close of its cost reporting year. A hospital filing a certified cost report that has been audited by the independent auditors of the hospital shall be given a 30-day extension if the Agency for Health Care Administration (AHCA) is notified in writing that a certified report is being filed. The hospital cost reporting year adopted for the purpose of this plan shall be the same as that for Title XVIII or Title V cost reporting, if applicable. A complete legible copy of the cost report shall be submitted to the Medicare intermediary and to AHCA, Bureau of Medicaid Program Analysis, Cost Reimbursement.

B. Cost reports available to AHCA as of March 31, 1990, shall be used to initiate this plan.

C. All hospitals are required to detail their costs for their entire reporting year making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals shall adhere to requirements of Section 2414.1, Provider Reimbursement Manual, CMS PUB. 15-1, as incorporated by reference in Rule 59G-6.010, Florida Administrative Code (F.A.C.) A prospective reimbursement rate, however, shall not be established for a new hospital based on a cost report for a period less than 12 months. For a new provider with no cost history, excluding new providers resulting from a change in ownership where the

previous provider participated in the program, the interim per diem rate shall be the lesser of:

a. the county reimbursement ceiling, if applicable; or

b. the budgeted rate approved by AHCA based on Section III of this plan.

Interim rates shall be cost settled for the interim rate period. Interim per diem rates shall not be approved for new providers resulting from a change in ownership. Medicaid reimbursement is hospital specific and is not provider specific.

D. The cost report shall be prepared in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA) as incorporated by reference in Rule 61H1-20.007, F.A.C., except as modified by the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 CFR 413.5 - 413.35 (2000) and further interpreted by the Provider Reimbursement Manual CMS PUB. 15-1, as incorporated by reference in Rule 59G-6.010, F.A.C., or as further modified by this plan.

E. If a provider submits a cost report late, after the 5 month period, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within 5 months, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be affected retroactively. Medicare granted exceptions to these time limits shall be accepted by AHCA.

F. A hospital which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a clearly marked "final" cost report in accordance with Section 2414.2, CMS PUB. 15-1, as

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incorporated by reference in Rule 59G-6.010, F.A.C. For the purposes of this plan, filing a final cost report is not required when:

1. the capital stock of a corporation is sold; or
2. partnership interest is sold as long as one of the original general partners continues in the partnership or one of the original limited partners becomes a general partner, or control remains unchanged.

Any change of ownership shall be reported to AHCA within 45 days after such change of ownership.

G. All Medicaid participating hospitals, are required to maintain the Florida Medicaid Log and financial and statistical records in accordance with 42 CFR 413.24 (a)-(c) (2000). In addition, a separate log shall be maintained to account for concurrent and non-concurrent nursery days. For purposes of this plan, statistical records shall include beneficiaries' medical records. These records shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General of the State of Florida, the General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). Beneficiaries' medical records shall be released to the above named persons for audit purposes upon proof of a beneficiary's consent to the release of medical records such as the Medicaid Consent Form, AHCA-Med Form 1005, as incorporated by reference in Rule 59G-5.080, (2), F.A.C.

H. Records of related organizations as defined by 42 CFR 413.17 (2000) shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General, GAO, or HHS.

I. AHCA shall retain all uniform cost reports submitted for a period of at least 5 years following the date of submission of such reports and shall maintain those reports pursuant to the record keeping requirements of 45 CFR 205.60 (2000). Access to submitted cost reports shall be in conformity with Chapter 119, Florida

Statutes. Upon request for a copy of any cost report, the hospital involved shall be notified as to the person making the request and what is being requested. Unless prohibited by a court of competent jurisdiction, the cost report shall be released to the requestor within a limited reasonable time from receipt of the request by the Agency for Health Care Administration. Reasonable time is defined as the time allowed to enable the agency to retrieve the record and delete exempt portions of the record.

II. Audits

A. Background

Medicaid (Title XIX), Maternal and Child Health and Crippled Children's Services (Title V), and Medicare (Title XVIII) requires that inpatient hospital services be reimbursed on a reasonable cost basis. To assure that payment of reasonable cost is being achieved, a comprehensive hospital audit program has been established to reduce the cost of auditing submitted cost reports under the above three programs, and to avoid duplicate auditing effort. The purpose is to have one audit of a participating hospital that shall serve the needs of all participating programs reimbursing the hospital for services rendered.

B. Common Audit Program

AHCA has entered into written agreements with Medicare intermediaries for participation in a common audit program of Titles V, XVIII and XIX. Under this agreement the intermediaries shall provide AHCA the result of desk and field audits of those participating hospitals located in Florida, Georgia, and Alabama.

C. Other Hospital Audits

For those hospitals not covered by the common audit agreement with Medicare intermediaries, AHCA shall be responsible for performance of desk and field audits.

AHCA shall:

1. Determine the scope and format for on-site audits;
2. Desk audit all cost reports within 6 months after their submission to AHCA;
3. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA, as incorporated by reference in Rule 61H1-20.008, F.A.C. (10/94);
4. Ensure that only those expense items that the plan has specified as allowable costs under Section III of this plan have been included by the hospital in the computation of the costs of the various services provided under Rule 59G-4.150, F.A.C;
5. Review to determine that the Florida Medicaid Log is properly maintained and current in those hospitals where its maintenance is required;
6. Issue, upon the conclusion of each full scope audit, a report which shall meet generally accepted auditing standards of the AICPA, as incorporated by reference in Rule 61H1-20.008, F.A.C., (10/94), and shall declare the auditor's opinion as to whether, in all material respects, the cost submitted by a hospital meets the requirements of this plan.

D. Retention

All audit reports received from Medicare intermediaries or issued by AHCA shall be kept in accordance with 45 CFR 205.60 (2000).

E. Overpayments and Underpayments

1. Overpayments for those years or partial years as determined by desk or field audit using prior approved State plans shall be reimbursable to AHCA as shall overpayments, attributable to unallowable costs only.
2. Overpayments in outpatient hospital services shall not be used to offset underpayments in inpatient hospital services and, conversely,

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overpayments in inpatient hospital services shall not be used to offset underpayments in outpatient hospital services.

3. The results of audits of outpatient hospital services shall be reported separately from audits of inpatient hospital services.
4. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.
5. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.
6. The terms of repayments shall be in accordance with Section 414.41, Florida Statutes.
7. All overpayments shall be reported by AHCA to HHS as required.
8. Information intentionally misrepresented by a hospital in the cost report shall result in the imposition of disciplinary action by the Florida Medicaid Program as provided for in Rule 59G-9.010, F.A.C.

F. Appeals

For audits conducted by AHCA, a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with Section 28-106, F.A.C, and Section 120.57, Florida Statutes, for any or all adjustments made by AHCA.

III. Allowable Costs

Allowable costs shall be determined using generally accepted accounting principles, except as modified by Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413.5 - 413.35 (2000) (excluding the inpatient routine nursing salary cost differential) and the guidelines in the Provider Reimbursement Manual CMS PUB. 15-1, as incorporated by reference in Rule 59G-6.010, F.A.C., and as further modified by Title

XIX of the Social Security Act (the Act), this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

A. Costs incurred by a hospital in meeting:

1. The definition of a hospital contained in 42 CFR 440.10 (2000) (for the care and treatment of patients with disorders other than mental diseases) and 42 CFR 440.140 (for individuals age 65 or older in institutions for mental diseases), (2000) in order to meet the requirements of Sections 1902(a)(13) and (20) of the Social Security Act;
2. The requirements established by the Agency for establishing and maintaining health standards under the authority of 42 CFR 431.610 (b) (2000); and
3. Any other requirements for licensing under Chapter 395.003, Florida Statutes, which are necessary for providing inpatient hospital services.

B. Medicaid reimbursement shall be limited to an amount, if any, by which the per diem calculation for an allowable claim exceeds the amount of third party benefits during the Medicaid benefit period.

C. Hospital inpatient general routine operating costs shall be the lesser of allowable costs, direct and indirect, incurred or the limits established by HHS under 42 CFR 413.30 (2000).

D. Malpractice insurance costs shall be apportioned to Medicaid in the ratio of Medicaid Patient Days to Total Patient Days.

E. Under this plan, hospitals shall be required to accept Medicaid reimbursement as payment in full for services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from patients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by patients. Bad debts shall not be considered as an allowable expense.